Agency for Healthcare Research and Quality
Advancing Excellence in Health Care

NATIONAL GUIDELINE CLEARINGHOUSE

General

Guideline Title

The American Psychiatric Association practice guideline for the pharmacological treatment of patients with alcohol use disorder.

Bibliographic Source(s)

American Psychiatric Association (APA). The American Psychiatric Association practice guideline for the pharmacological treatment of patients with alcohol use disorder. Washington (DC): American Psychiatric Association (APA); 2018 Jan. 214 p. [487 references]

Guideline Status

This is the current release of the guideline.

This guideline meets NGC's 2013 (revised) inclusion criteria.

NEATS Assessment

National Guideline Clearinghouse (NGC) has assessed this guideline's adherence to standards of trustworthiness, derived from the Institute of Medicine's report Clinical Practice Guidelines We Can Trust.

= Poor = Fair = Good = Very Good = Excellent

Assessment	Standard of Trustworthiness
YES	Disclosure of Guideline Funding Source
	Disclosure and Management of Financial Conflict of Interests
	Guideline Development Group Composition
YES	Multidisciplinary Group
YES	Methodologist Involvement

	Patient and Public Perspectives
	Use of a Systematic Review of Evidence
	Search Strategy
	Study Selection
	Synthesis of Evidence
	Evidence Foundations for and Rating Strength of Recommendations
	Grading the Quality or Strength of Evidence
	Benefits and Harms of Recommendations
	Evidence Summary Supporting Recommendations
	Rating the Strength of Recommendations
	Specific and Unambiguous Articulation of Recommendations
	External Review
	Updating

Recommendations

Major Recommendations

The definitions for the strength of the recommendations (recommendation [1] or suggestion [2]) and the strength of evidence (high [A], moderate [B], or low [C]) are provided at the end of the "Major Recommendations" field.

Guideline Statements

Assessment and Determination of Treatment Goals

The American Psychiatric Association (APA) *recommends* (1C) that the initial psychiatric evaluation of a patient with suspected alcohol use disorder include assessment of current and past use of tobacco and alcohol as well as any misuse of other substances, including prescribed or over-the-counter medications or supplements.

APA *recommends* (1C) that the initial psychiatric evaluation of a patient with suspected alcohol use disorder include a quantitative behavioral measure to detect the presence of alcohol misuse and assess its severity.

APA *suggests* (2C) that physiological biomarkers be used to identify persistently elevated levels of alcohol consumption as part of the initial evaluation of patients with alcohol use disorder or in the treatment of individuals who have an indication for ongoing monitoring of their alcohol use.

APA *recommends* (1C) that patients be assessed for co-occurring conditions (including substance use disorders, other psychiatric disorders, and other medical disorders) that may influence the selection of pharmacotherapy for alcohol use disorder.

APA *suggests* (2C) that the initial goals of treatment of alcohol use disorder (e.g., abstinence from alcohol use, reduction or moderation of alcohol use, other elements of harm reduction) be agreed on between the patient and clinician and that this agreement be documented in the medical record.
APA *suggests* (2C) that the initial goals of treatment of alcohol use disorder include discussion of the patient's legal obligations (e.g., abstinence from alcohol use, monitoring of abstinence) and that this discussion be documented in the medical record.
APA *suggests* (2C) that the initial goals of treatment of alcohol use disorder include discussion of risks to self (e.g., physical health, occupational functioning, legal involvement) and others (e.g., impaired driving) from continued use of alcohol and that this discussion be documented in the medical record.
APA *recommends* (1C) that patients with alcohol use disorder have a documented comprehensive and person-centered treatment plan that includes evidence-based nonpharmacological and pharmacological treatments.

Selection of a Pharmacotherapy

APA *recommends* (1B) that naltrexone or acamprosate be offered to patients with moderate to severe alcohol use disorder who
- Have a goal of reducing alcohol consumption or achieving abstinence,
- Prefer pharmacotherapy or have not responded to nonpharmacological treatments alone, and
- Have no contraindications to the use of these medications.

APA *suggests* (2C) that disulfiram be offered to patients with moderate to severe alcohol use disorder who
- Have a goal of achieving abstinence,
- Prefer disulfiram or are intolerant to or have not responded to naltrexone and acamprosate,
- Are capable of understanding the risks of alcohol consumption while taking disulfiram, and
- Have no contraindications to the use of this medication.

APA *suggests* (2C) that topiramate or gabapentin be offered to patients with moderate to severe alcohol use disorder who
- Have a goal of reducing alcohol consumption or achieving abstinence,
- Prefer topiramate or gabapentin or are intolerant to or have not responded to naltrexone and acamprosate, and
- Have no contraindications to the use of these medications.

Recommendations Against Use of Specific Medications

APA *recommends* (1B) that antidepressant medications not be used for treatment of alcohol use disorder unless there is evidence of a co-occurring disorder for which an antidepressant is an indicated treatment.
APA *recommends* (1C) that in individuals with alcohol use disorder, benzodiazepines not be used unless treating acute alcohol withdrawal or unless a co-occurring disorder exists for which a benzodiazepine is an indicated treatment.
APA *recommends* (1C) that for pregnant or breastfeeding women with alcohol use disorder, pharmacological treatments not be used unless treating acute alcohol withdrawal with benzodiazepines or unless a co-occurring disorder exists that warrants pharmacological treatment.
APA *recommends* (1C) that acamprosate not be used by patients who have severe renal impairment.
APA *recommends* (1C) that for individuals with mild to moderate renal impairment, acamprosate not be used as a first-line treatment and, if used, the dose of acamprosate be reduced compared with recommended doses in individuals with normal renal function.
APA *recommends* (1C) that naltrexone not be used by patients who have acute hepatitis or hepatic failure.
APA *recommends* (1C) that naltrexone not be used as a treatment for alcohol use disorder by individuals who use opioids or who have an anticipated need for opioids.

Treatment of Alcohol Use Disorder and Co-occurring Opioid Use Disorder

APA *recommends* (1C) that in patients with alcohol use disorder and co-occurring opioid use disorder, naltrexone be prescribed to individuals who

Wish to abstain from opioid use and either abstain from or reduce alcohol use and

Are able to abstain from opioid use for a clinically appropriate time prior to naltrexone initiation.

Definitions

Rating the Strength of the Recommendations

"Recommendation" (denoted by the numeral 1) indicates confidence that the benefits of the intervention clearly outweigh the harms.

"Suggestion" (denoted by the numeral 2) indicates greater uncertainty. Although the benefits of the statement are still viewed as outweighing the harms, the balance of benefits and harms is more difficult to judge, or either the benefits or the harms may be less clear.

Rating the Strength of Supporting Research Evidence

High (denoted by the letter *A*) = High confidence that the evidence reflects the true effect. Further research is very unlikely to change confidence in the estimate of effect.

Moderate (denoted by the letter *B*) = Moderate confidence that the evidence reflects the true effect. Further research may change confidence in the estimate of effect and may change the estimate.

Low (denoted by the letter *C*) = Low confidence that the evidence reflects the true effect. Further research is likely to change confidence in the estimate of effect and is likely to change the estimate.

The Agency for Healthcare Research and Quality (AHRQ) has an additional category of insufficient for evidence that is unavailable or does not permit estimation of an effect. The American Psychiatric Association (APA) uses the low rating when evidence is insufficient because there is low confidence in the conclusion and further research, if conducted, would likely change the estimated effect or confidence in the estimated effect.

Clinical Algorithm(s)

None provided

Scope

Disease/Condition(s)

Alcohol use disorder

Other Disease/Condition(s) Addressed

Opioid use disorder

Guideline Category

Assessment of Therapeutic Effectiveness

Evaluation

Treatment

Clinical Specialty

Family Practice

Internal Medicine

Psychiatry

Intended Users

Advanced Practice Nurses

Physicians

Guideline Objective(s)

To improve the quality of care and treatment outcomes for patients with alcohol use disorder (AUD), as defined by the American Psychiatric Association (APA) *Diagnostic and Statistical Manual of Mental Disorders, 5th Edition (DSM-5)*

Target Population

Patients with alcohol use disorder

Note: The guideline does not address the management of individuals who are intoxicated with alcohol, who require pharmacotherapy for the acute treatment of alcohol withdrawal, or who are experiencing other acute medical problems related to alcohol use.

Interventions and Practices Considered

1. Initial psychiatric evaluation
    - Assessment of current and past use of tobacco and alcohol
    - Assessment of misuse of other substances
    - Use of a quantitative behavioral measure
    - Use of physiological biomarkers
2. Assessment for co-occurring conditions
3. Documentation of initial goals agreed upon by patient and clinician
    - Discussion of the patient's legal obligations
    - Discussion of risk to self and others from continued use of alcohol
4. Documented comprehensive and person-centered treatment plan
5. Pharmacotherapy
    - Naltrexone
    - Acamprosate
    - Disulfiram
    - Topiramate
    - Gabapentin

Note: Although the following were considered, it is recommended they not be used in this clinical context: antidepressant medication; benzodiazepines; pharmacological treatments for pregnant or breastfeeding women.

Major Outcomes Considered

- Alcohol consumption-related outcomes
    - Return to any drinking
    - Return to heavy drinking
    - Drinking days

    - Heavy drinking days
    - Drinks per drinking day
    - Time to lapse or relapse
- Health outcomes
    - Accidents
    - Injuries
    - Quality of life
    - Function
    - Mortality
- Adverse effects, including study withdrawal

Methodology

Methods Used to Collect/Select the Evidence

Hand-searches of Published Literature (Primary Sources)

Hand-searches of Published Literature (Secondary Sources)

Searches of Electronic Databases

Description of Methods Used to Collect/Select the Evidence

Systematic Review Methodology

The Agency for Healthcare Research and Quality's (AHRQ's) systematic review *Pharmacotherapy for Adults With Alcohol-Use Disorders in Outpatient Settings* (Jonas et al. 2014) (see the "Availability of Companion Documents" field) served as the predominant source of information for this guideline. Both the AHRQ review and the guideline are based on a systematic search of available research evidence using MEDLINE (PubMed), Cochrane Library, PsycINFO, CINAHL, and EMBASE databases (see Table 1 in the original guideline document). The search terms and limits used are available in Appendix A in the original guideline document. Results were limited to English-language, adult (18 and older), and human-only studies. The search that informed the AHRQ review was from January 1, 1970 to October 11, 2013, and the subsequent search of the literature by the American Psychiatric Association (APA) staff was from September 1, 2013 through April 24, 2016. Literature from the updated search was screened by two reviewers according to APA's general screening criteria: randomized controlled trial (RCT), systematic review or meta-analysis, or observational study with a sample of at least 50 individuals; human; study of the effects of a specific intervention or psychiatric disorder or symptoms. Abstracts were then reviewed by one individual, with verification by a second reviewer to determine whether they met eligibility criteria.

Studies were included if subjects were adults (age 18 years or older) with alcohol use disorder (AUD), including alcohol abuse or alcohol dependence as defined in the APA *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision* (DSM-IV-TR), who received treatment with medications approved by the U.S. Food and Drug Administration (FDA) for treating alcohol dependence (acamprosate, disulfiram, naltrexone) or with medications that have been used off-label or are under investigation for treatment of AUD (e.g., amitriptyline, aripiprazole, atomoxetine, baclofen, buspirone, citalopram, desipramine, escitalopram, fluoxetine, fluvoxamine, gabapentin, imipramine, nalmefene, olanzapine, ondansetron, paroxetine, prazosin, quetiapine, sertraline, topiramate, valproate, varenicline, viloxazine). Outcomes could include consumption-related outcomes (e.g., return to any drinking, return to heavy drinking, drinking days, heavy drinking days, drinks per drinking day, time to lapse or relapse), health outcomes (e.g., accidents, injuries, quality of life, function, mortality), and adverse events (including study withdrawal). Studies also needed to be published in English and to include at least 12 weeks of outpatient follow-up from the time of treatment initiation.

Exclusion criteria were studies of children and adolescents under 18 years of age, trials in which the purpose of pharmacotherapy was to treat alcohol withdrawal, trials with craving or cue reactivity as primary outcomes, studies that were conducted predominantly in inpatient settings or with follow-up of less than 12 weeks, and those that were published in languages other than English.

Available guidelines from other organizations were also reviewed.

Additional targeted searches were conducted in MEDLINE (PubMed) on alcohol biomarkers, patient preferences in AUD pharmacotherapy, and use of pharmacotherapy for AUD during pregnancy and while breastfeeding. The search terms, limits used, and dates of these searches are available in Appendix A in the original guideline document. Results were limited to English-language, adult (18 and older), and human only studies. These titles and abstracts were reviewed for relevance by one individual.

Number of Source Documents

- Studies in qualitative synthesis: 149
- Articles in qualitative synthesis: 184
- Studies in quantitative synthesis: 96

See Table 1 in the original guideline document (see the "Availability of Companion Documents" field) for literature search results.

Methods Used to Assess the Quality and Strength of the Evidence

Weighting According to a Rating Scheme (Scheme Given)

Rating Scheme for the Strength of the Evidence

Rating the Strength of Supporting Research Evidence

High (denoted by the letter *A*) = High confidence that the evidence reflects the true effect. Further research is very unlikely to change confidence in the estimate of effect.

Moderate (denoted by the letter *B*) = Moderate confidence that the evidence reflects the true effect. Further research may change confidence in the estimate of effect and may change the estimate.

Low (denoted by the letter *C*) = Low confidence that the evidence reflects the true effect. Further research is likely to change confidence in the estimate of effect and is likely to change the estimate.

The Agency for Healthcare Research and Quality (AHRQ) has an additional category of insufficient for evidence that is unavailable or does not permit estimation of an effect. The American Psychiatric Association (APA) uses the low rating when evidence is insufficient because there is low confidence in the conclusion and further research, if conducted, would likely change the estimated effect or confidence in the estimated effect.

Methods Used to Analyze the Evidence

Meta-Analysis

Review of Published Meta-Analyses

Systematic Review with Evidence Tables

Description of the Methods Used to Analyze the Evidence

Systematic Review Methodology

For each trial identified for inclusion from the updated search, risk of bias was determined on the basis of information from each study that was extracted by one reviewer and checked for accuracy by another reviewer. In addition to specific information about each reported outcome, extracted information included citation; study design; treatment arms (including doses, sample sizes); co-intervention, if applicable; trial duration and follow-up duration, if applicable; country; setting; funding source; recruitment method; sample characteristics (mean age, percent nonwhite, percent female, percent with co-occurring condition); methods for randomization and allocation concealment; similarity of groups at baseline; overall and differential attrition; cross-overs or other contamination in group composition; adequacy of intervention fidelity; adequacy of adherence; appropriate masking of patients, outcome assessors, and care providers; validity and reliability of outcome measures; appropriateness of statistical methods and handling of missing data; appropriate methods for assessing harms (e.g., well-defined, pre-specified, well-described valid/reliable ascertainment); and adequate follow-up period for assessing harms.

Summary tables (see Appendices B and C in the original guideline document) include specific details for each study identified for inclusion from the updated literature search and also include data on studies identified for inclusion in the Agency for Healthcare Research and Quality (AHRQ) review. For studies from the AHRQ review, study details were obtained from tables published with the AHRQ review by one reviewer and double-checked by a second reviewer. Data on elements that were not included in the AHRQ review were extracted from the original articles as described above for articles from the updated search.

Rating the Strength of Supporting Research Evidence

Strength of supporting research evidence describes the level of confidence that findings from scientific observation and testing of an effect of an intervention reflect the true effect. Confidence is enhanced by such factors as rigorous study design and minimal potential for study bias. Three ratings are used: high, moderate, and low (see the "Rating Scheme for the Strength of the Evidence" field).

Ratings were determined, in accordance with AHRQ's Methods *Guide for Effectiveness and Comparative Effectiveness Reviews*, by the methodologist and reviewed by members of the Systematic Review Group (SRG) and Guideline Writing Group (GWG). Available clinical trials were assessed across four primary domains: risk of bias, consistency of findings across studies, directness of the effect on a specific health outcome, and precision of the estimate of effect.

Methods Used to Formulate the Recommendations

Expert Consensus (Delphi)

Description of Methods Used to Formulate the Recommendations

Overview of the Development Process

This guideline was developed using a process intended to meet standards of the Institute of Medicine (2011), the *Principles for the Development of Specialty Society Clinical Guidelines of the Council of Medical Specialty Societies* (2012), and the requirements of the Agency for Healthcare Research and Quality (AHRQ) for inclusion of a guideline in the National Guideline Clearinghouse. The development process is fully described in a document available on the American Psychiatric Association (APA) Web site (see also the "Availability of Companion Documents" field).

Guideline Writing Group (GWG) Composition

The GWG was multidisciplinary and included individuals from several medical specialties. It included two experts on alcohol use disorder (AUD), one of whom is board-certified in both internal medicine and addiction medicine and the other of whom is board-certified in psychiatry, with subspecialty certification in child and adolescent psychiatry. In addition, the GWG included seven psychiatrists and one registered

nurse with general research and clinical expertise. This distribution of GWG membership was intended to provide diverse and balanced views on the guideline topic to minimize potential bias. One consultant was also added to the GWG to provide input on quality measure considerations. An additional consultant assisted with drafting of guideline text. The vice-chair of the GWG provided methodological expertise on such topics as appraising the strength of research evidence. The GWG was also diverse and balanced with respect to other characteristics, such as geographical location and demographic background.

Mental Health America reviewed the draft and provided perspective from patients, families, and other care partners.

Rating the Strength of Recommendations

Each guideline statement is separately rated to indicate strength of recommendation and strength of supporting research evidence. *Strength of recommendation* describes the level of confidence that potential benefits of an intervention outweigh potential harms. This level of confidence is informed by available evidence, which includes evidence from clinical trials as well as expert opinion and patient values and preferences. As described in the section "Rating the Strength of Supporting Research Evidence," this rating is a consensus judgment of the authors of the guideline and is endorsed by the American Psychiatric Association (APA) Board of Trustees.

There are two possible ratings: recommendation or suggestion. A *recommendation* (denoted by the numeral 1) indicates confidence that the benefits of the intervention clearly outweigh harms. A *suggestion* (denoted by the numeral 2) indicates greater uncertainty. Although the benefits of the statement are still viewed as outweighing the harms, the balance of benefits and harms is more difficult to judge, or either the benefits or the harms may be less clear. With a suggestion, patient values and preferences may be more variable, and this can influence the clinical decision that is ultimately made. These strengths of recommendation correspond to ratings of *strong* or *weak* (also termed *conditional*) as defined under the Grading of Recommendations Assessment, Development and Evaluation (GRADE) method for rating recommendations in clinical practice guidelines (described in publications such as Guyatt et al. 2008 and others available on the Web site of the GRADE Working Group at http://gradeworkinggroup.org). See the "Rating Scheme for the Strength of the Recommendations" field.

When a negative statement is made, ratings of strength of recommendation should be understood as meaning the inverse of the above (e.g., *recommendation* indicates confidence that harms clearly outweigh benefits).

The GWG determined ratings of strength of recommendation by a modified Delphi method using blind, iterative voting and discussion. In order for the GWG members to be able to ask for clarifications about the evidence, the wording of statements, or the process, the vice-chair of the GWG served as a resource and did not vote on statements. All other formally appointed GWG members, including the chair, voted.

In weighing potential benefits and harms, GWG members considered the strength of supporting research evidence, their own clinical experiences and opinions, and patient preferences. For recommendations, at least eight out of nine members must have voted to recommend the intervention or assessment after two rounds of voting, and at most one member was allowed to vote other than "recommend" the intervention or assessment. On the basis of the discussion among the GWG members, adjustments to the wording of recommendations could be made between the voting rounds. If this level of consensus was not achieved, the GWG could have agreed to make a suggestion rather than a recommendation. No suggestion or statement could have been made if three or more members voted "no statement." Differences of opinion within the group about ratings of strength of recommendation, if any, are described in the subsection "Balancing of Potential Benefits and Harms in Rating the Strength of the Guideline Statement" for each statement in the original guideline document.

Rating Scheme for the Strength of the Recommendations

Rating the Strength of the Recommendations

"Recommendation" (denoted by the numeral 1) indicates confidence that the benefits of the intervention clearly outweigh the harms.

"Suggestion" (denoted by the numeral 2) indicates greater uncertainty. Although the benefits of the statement are still viewed as outweighing the harms, the balance of benefits and harms is more difficult to judge, or either the benefits or the harms may be less clear.

Cost Analysis

Published cost analyses were reviewed.

Method of Guideline Validation

External Peer Review

Internal Peer Review

Description of Method of Guideline Validation

External Review

This guideline was made available for review in February 2017 by stakeholders, including the American Psychiatric Association (APA) membership, scientific and clinical experts, allied organizations, and the public. In addition, a number of patient advocacy organizations were invited for input. Forty-eight individuals and 12 organizations submitted comments on the guideline (see the section "Individuals and Organizations That Submitted Comments" in the original guideline document for a list of the names). Dr. Raymond Anton provided significant helpful input on the implementation section of Statement 3 (Use of Physiological Biomarkers). The Chair and Co-chair of the Guideline Writing Group (GWG) reviewed and addressed all comments received; substantive issues were reviewed by the GWG.

Approval

The guideline was submitted to the APA Assembly and APA Board of Trustees and approved on May 20, 2017 and July 16, 2017, respectively.

Evidence Supporting the Recommendations

Type of Evidence Supporting the Recommendations

The type of supporting evidence is identified and graded for each guideline statement (see the "Major Recommendations" field).

Benefits/Harms of Implementing the Guideline Recommendations

Potential Benefits

Accurate assessment and appropriate treatment of patients with alcohol use disorder

Refer to the "Balancing of Potential Benefits and Harms in Rating the Strength of the Guideline Statement" sections under each statement in the original guideline document for a discussion of specific benefits and balancing of benefits and harms.

Potential Harms

- Adverse effects of interventions, including medications
- In this guideline, harms are broadly defined and may include serious adverse events, less serious adverse events that affect tolerability, minor adverse events, negative effects of the intervention on quality of life, barriers and inconveniences associated with treatment, direct and indirect costs of the intervention (including opportunity costs), and other negative aspects of the treatment that may influence decision making by the patient, the clinician, or both.

Refer to the "Balancing of Potential Benefits and Harms in Rating the Strength of the Guideline Statement" sections under each statement in the original guideline document for a discussion of specific harms and balancing of benefits and harms.

Contraindications

Contraindications

- Pharmacotherapies for alcohol-related disorder (AUD) may interact with treatments for other disorders, and specific medical conditions may be contraindications for the use of specific pharmacotherapies for AUD.
- Acamprosate is contraindicated if estimated creatinine clearance (CrCl) is less than 30 mL/min or estimated glomerular filtration rate (eGFR) is less than 30 mL/min/1.73 m^2; dose reduction may be necessary for CrCl values between 30 and 50 mL/min or eGFR values between 30 and 59 mL/min/1.73 m^2.
- Naltrexone must be used cautiously in individuals with hepatic impairment.
- Disulfiram is appropriate only for individuals seeking abstinence and is contraindicated in patients who are actively using alcohol or products containing alcohol.
- Disulfiram should not be given to individuals who have recently received metronidazole, paraldehyde, alcohol (within 12 hours), or alcohol-containing preparations. It is also noted to be contraindicated in the presence of severe myocardial disease or coronary occlusion. Disulfiram is noted to be contraindicated in the presence of psychosis or in individuals with hypersensitivity to disulfiram or thiuram derivatives used in pesticides and rubber production.

Qualifying Statements

Qualifying Statements

Proper Use of Guidelines

The American Psychiatric Association (APA) Practice Guidelines are assessments of current scientific and clinical information provided as an educational service. The guidelines 1) should not be considered as a statement of the standard of care or inclusive of all proper treatments or methods of care; 2) are not continually updated and may not reflect the most recent evidence, as new evidence may emerge between the time information is developed and when the guidelines are published or read; 3) address only the question(s) or issue(s) specifically identified; 4) do not mandate any particular course of medical care; 5) are not intended to substitute for the independent professional judgment of the treating provider; and 6)

do not account for individual variation among patients. As such, it is not possible to draw conclusions about the effects of omitting a particular recommendation, either in general or for a specific patient. Furthermore, adherence to these guidelines will not ensure a successful outcome for every individual, nor should these guidelines be interpreted as including all proper methods of evaluation and care or excluding other acceptable methods of evaluation and care aimed at the same results. The ultimate recommendation regarding a particular assessment, clinical procedure, or treatment plan must be made by the clinician in light of the psychiatric evaluation, other clinical data, and the diagnostic and treatment options available. Such recommendations should be made in collaboration with the patient, whenever possible, and incorporate the patient's personal and sociocultural preferences and values in order to enhance the therapeutic alliance, adherence to treatment, and treatment outcomes. For all of these reasons, the APA cautions against the use of guidelines in litigation. Use of these guidelines is voluntary. APA provides the guidelines on an "as is" basis and makes no warranty, expressed or implied, regarding them. APA assumes no responsibility for any injury or damage to persons or property arising out of or related to any use of the guidelines or for any errors or omissions.

Implementation of the Guideline

Description of Implementation Strategy

Implementation

Refer to the original guideline document for discussion of implementation considerations and suggestions for each guideline statement.

Quality Measurement Considerations

Refer to the original guideline document for discussion of quality measures considerations and suggestions for each guideline statement and for additional information on the use of guidelines to enhance quality of care.

Implementation Tools

Audit Criteria/Indicators

Quick Reference Guides/Physician Guides

Slide Presentation

Staff Training/Competency Material

For information about availability, see the *Availability of Companion Documents* and *Patient Resources* fields below.

Institute of Medicine (IOM) National Healthcare Quality Report Categories

IOM Care Need

Getting Better

Living with Illness

IOM Domain

Effectiveness

Patient-centeredness

Identifying Information and Availability

Bibliographic Source(s)

American Psychiatric Association (APA). The American Psychiatric Association practice guideline for the pharmacological treatment of patients with alcohol use disorder. Washington (DC): American Psychiatric Association (APA); 2018 Jan. 214 p. [487 references]

Adaptation

Not applicable: The guideline was not adapted from another source.

Date Released

2018 Jan

Guideline Developer(s)

American Psychiatric Association - Medical Specialty Society

Source(s) of Funding

This guideline development project was funded and supported by the American Psychiatric Association (APA) without any involvement of industry or external funding.

Guideline Committee

Guideline Writing Group (GWG)

Composition of Group That Authored the Guideline

Guideline Writing Group (GWG): Victor I. Reus, MD (*Chair*); Laura J. Fochtmann, MD, MBI (*Vice-Chair, Methodologist*); Oscar Bukstein, MD, MPH; A. Evan Eyler, MD, MPH; Donald M. Hilty, MD; Marcela Horvitz-Lennon, MD, MPH; Jane Mahoney, PhD, RN, PMHCNS-BC; Jagoda Pasic, MD, PhD; Michael Weaver, MD; Cheryl D. Wills, MD; Jack McIntyre, MD (*Consultant*)

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Steering Committee on Practice Guidelines: Michael J. Vergare, MD (*Chair*); Daniel J. Anzia, MD (*Vice-Chair*); Thomas J. Craig, MD; Deborah Cowley, MD; Laura J. Fochtmann, MD, MBI (*Consultant*, *Methodologist*); David A. Kahn, MD; John M. Oldham, MD; Carlos N. Pato, MD, PhD; Joel Yager, MD (*Consultant*)

American Psychiatric Association (APA) Assembly Liaisons: John P. D. Shemo, MD (*Chair of Area Liaisons*); John M. de Figueiredo, MD; Marvin Koss, MD; Annette L. Hanson, MD; Bhasker Dave, MD; Robert M. McCarron, DO; Jason W. Hunziker, MD

Financial Disclosures/Conflicts of Interest

Management of Potential Conflicts of Interest

Members of the Guideline Writing Group (GWG) are required to disclose all potential conflicts of interest before appointment, before and during guideline development, and on publication. If any potential conflicts are found or disclosed during the guideline development process, the member must recuse himself or herself from any related discussion and voting on a related recommendation. The members of both the GWG and the Systematic Review Group (SRG), as well as the two consultants, reported no conflicts of interest. The Disclosures section includes more detailed disclosure information for each GWG and SRG member and for the consultants involved in the guideline's development.

Refer to the "Disclosures" section in the original guideline document for a list of disclosures.

Guideline Status

This is the current release of the guideline.

This guideline meets NGC's 2013 (revised) inclusion criteria.

Guideline Availability

Available from the PsychiatryOnline Web site .

Availability of Companion Documents

The following are available:

Jonas DE, Amick HR, Feltner C, Bobashev G, Thomas K, Wines R, Kim MM, Shanahan E, Gass CE, Rowe CJ, Garbutt JC. Pharmacotherapy for adults with alcohol-use disorders in outpatient settings. Comparative Effectiveness Review No. 134. Publication No. 14-EHC029-EF. Rockville (MD): Agency for Healthcare Research and Quality; 2014 May. 447 p. Available from the Agency for Healthcare Research and Quality (AHRQ) Web site .

Reus VI, Fochtmann LJ, Bukstein O, Eyler AE, Hilty DM, Horvitz-Lennon M, Mahoney J, Pasic J, Weaver M, Wills CD, McIntyre J, Kid J, Yager J, Hong S. The American Psychiatric Association practice guideline for the pharmacological treatment of patients with alcohol use disorder. Executive summary. 2018 Jan;175(1):86-90. Available from the American Journal of Psychiatry Web site .

Pharmacologic treatment of patients with alcohol-use disorder. CME course. [internet]. Arlington (VA): American Psychiatric Association (APA). Available from the American Psychiatric Association (APA) Web site .

New development process for practice guidelines of the American Psychiatric Association. Arlington (VA): American Psychiatric Association (APA); 2011 Dec 20. 16 p. Available from the APA Web site .

Patient Resources

None available

NGC Status

This NGC summary was completed by ECRI Institute on April 2, 2018. The information was verified by the guideline developer on April 30, 2018.

This NEATS assessment was completed by ECRI Institute on April 10, 2018. The information was verified by the guideline developer on April 30, 2018.

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